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B. Inflation factor to recognize economic conditions and trends during the time period covered by the facility's prospective per diem rate.

The index used to determine the inflation factor will be the Health Care Financing Administration Nursing Home Market Basket Index (MBI)- Without Capital and Medical Fees.

Each provider's operating costs will be indexed to a mid-year point of February 28 for operating Year 1.

The inflation factor will be the percentage change in the most current available actual or forecast MBI for the previous calendar year.

C. Incentive to Reduce Increases in Cost

As an incentive to reduce the increases in the Administrative and General (A&G) and Room and Board (R&B) cost center, the Department will share with the provider the savings below the A&G/R&B ceiling in accordance with the formula described below:

$A = [1/2 (B-C)] \leq \$1.00$

Where:
A = Allowable Incentive per diem
B = A&G/R&B ceiling per diem
C = Allowable A&G/R&B per diem from the base year's cost report

D. Cost Centers for Rate Calculation

For the purpose of rate calculation, costs will be grouped into four major cost centers. These are:

1. Direct Patient Care (DPC)

2. Administration and General (A&G)

3. Room and Board (R&B)

4. Facility costs (FC)

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E. Case-Mix Adjustment

In assuring the prospective reimbursement system addresses the needs of residents of ICF/MR facilities, a case mix adjustment factor will be incorporated into the reimbursement system. The case-mix index will be used to adjust the reimbursement levels in the Direct Patient Care cost center. The key objective of the case-mix adjustment is to link reimbursement to the acuity level of residents in a facility. To accomplish this objective, the Department utilizes level of care criteria which classify ICF/MR residents into one of three levels, with Level I representing the highest level of need. Corresponding to each level of care, the relative values are as follows:

Level I	1.077
Level II	0.953
Level III	0.768

Using these level specific relative values, a provider specific base year case-mix index (CMI) will be derived. The CMI represents the weighted average of the residents' level of care divided by the total number of residents in the facility. The CMI is calculated as follows:

$$[(A \times 1.077)+(B \times .953)+(C \times .768)]/N = CMI$$

WHERE:
A = Number of Level I residents
B = Number of Level II residents
C = Number of Level III residents
N = Total number of provider's residents

F. Calculation of the Prospective Per Diem Rate

A prospective per diem rate for each of the three levels of ICF/MR classification will be determined for each provider. Payment will be made based on the rate for the level of classification of the recipient.

The provider's Direct Patient Care(DPC) allowable cost per diem will be divided by the provider's case-mix index to determine the cost at a value of 1.00 for the base year. The adjusted DPC is then multiplied by the relative value of the level of

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classification to determine the DPC component of the rate. To this, will be added the allowable cost per diem A & G and R & B amount (as constrained by the ceiling described in Section V.,B.) and the allowable facility cost per diem. The formula for the rates will be as follows:

The formula for Year 1 is:

(A1 x RV) + C1 + D + E = PR (Year 1)

The formula for Year 2 is:

[(A1 x RV) + C1) x (1 + MBI)] + D + E = PR (Year 2)

The formula for Year 3 is:

[(A2 x RV) + C2) x (1 + MBI)] + D + E = PR (Year 3)

Where:

A = Allowable DPC per diem adjusted to a value of 1.00
B = The relative value of the level of classification.
C = Allowable A&G and R&B per diem
D = Allowable incentive per diem
E = Allowable facility cost per diem
MBI = Market Basket Index
PR = prospective rate
RV = the relative value for the level
"1" = The numerical subscript means the date of the data used in the formula. For example, "A1" means the base direct patient care costs established in the base year, while "A2" would refer to the base direct patient care costs adjusted by the MBI

Each provider will have three prospective rates, one for each of the three levels of care(I, II, and III.)

G. Effective dates of prospective rates

Rates will be effective September 1 of each year for each facility. In addition, the case mix index for

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each facility will be reviewed at the mid point of each year. At that time, the rate will be readjusted to reflect the current case mix index.

H. Calculation of rates for existing providers that do not have actuals as of June 30, 1990, and for new providers entering the program after September 1, 1990

For existing and for new providers entering the program that do not have actuals, the provider's interim prospective per diem rate will become the sum of:

1. The state wide average patient care cost per diem for each level plus;

2. The A&G and R&B ceiling (as described in Section V.B.) per diem plus;

3. Facility cost per diem as determined by using the Medicare principles of reimbursement.

After six months of operation or at the provider's fiscal year end, whichever comes later, the provider will submit a completed cost report. This cost report must be submitted no later than 90 days after the completion of the six month period or the fiscal year end, whichever comes later. This will be audited to determine the actual allowable and reasonable cost for the provider. A final prospective rate will be established at that time, and retroactive settlement will take place.

I. Changes of provider by sale of an existing facility

When a change of ownership occurs, the provider's prospective rate per diem will become the sum of:

1. The patient care cost per diem for each level, established for the previous owner plus;

2. The A&G and R&B per diem established for the previous owner; plus

3. Allowable facility costs determined by using the Medicare principles of reimbursement.

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J. Changes of ownership by lease of an existing facility

When a change of ownership occurs, the provider's prospective per diem rate will become the sum of:

1. The patient care cost per diem for each level established for the previous owner; plus

2. The A&G and R&B per diem established for the previous owner; plus

3. The lower of allowable facility cost or the ceiling on lease cost as described by this plan.

K. Sale/Leaseback of and exiting facility

When a sale/leaseback of an existing facility occurs, the provider's prospective rate will remain the same as before the transaction.

V. ESTABLISHMENT OF CEILINGS

Ceilings on the four major cost centers will be established as follow:

A. Direct Patient Care

No ceiling will be imposed on this cost center.

B. A&G and R&B

The per diem costs for administration and general and for room and board will be grouped together for the establishment of a ceiling. This ceiling will be calculated at 110% of the median of allowable costs for the base year, indexed (using the index described in Section IV.B.) to 12/31 of the base year. The ceiling will then be indexed (using the index described in Section IV.B.) to the mid-point of year 1 and set. For years 2 and 3, the ceiling will not be recalculated, but rather will be indexed forward using the appropriate inflation factor described earlier in these regulations.

C. Facility Cost

No ceiling will be imposed on this cost center, except in relation to leases.

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Effective for leases executed and binding on both parties on or after September 1, 1990, total allowable lease costs for the entire term of the lease for each facility will be limited to an amount determined by a discounted cash flow technique which will provide the lessor and annual rate of return on the fair market value of the facility equal to one times the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for the twelve months prior to the date the facility became a provider in the New Mexico Medicaid program. The rates of interest for this fund are published in both the Federal Register and the Commerce Clearing House (CCH).

The rate of return described above will be exclusive of any escalator clauses contained in the lease. The effect of escalator clauses will be considered at the time they become effective and the reasonableness of such clauses will be determined by the inflation factor described in Section IV, B of these regulations.

Any appraisal necessary to determine the fair market value of the facility will be the sole responsibility of the provider an is not an allowable cost for reimbursement under the program. The appraisals must be conducted by an appraiser certified by a nationally recognized entity, and such appraiser must be familiar with the health care industry, specifically long term care, and must be familiar with geographic area in which the facility is located. Prior to the appraisal taking place, the provider must submit to the Department the name of the appraiser, a copy of his/her certification, and a brief description of the appraiser's relevant experience. The use of a particular appraiser is subject to the approval of the Department.

VI. ADJUSTMENTS TO BASE YEAR COSTS

Since rebasing of the prospective per diem rate will take place every three years, the Department recognizes that certain circumstances may warrant an adjustment to the base rate. Therefor, the provider may request such an adjustment for the following reasons:

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A. Additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation authorities, or applicable law (e.g. minimum staffing requirements, minimum wage change, property tax increases, etc.)

B. Additional costs incurred as a result of uninsurable losses from catastrophic occurrences.

C. Additional costs of approved expansion, remodeling or purchase of equipment.

Such additional costs must reach minimum of $5,000 for facilities with 16 or more beds and $1000 for facilities with 15 or less beds, of incurred cost per year for rebasing to be considered. The provider may request consideration of such rebasing no more than twice in its fiscal year. The provider is encouraged to submit such rebasing requests before the cost is actually incurred if possible. The Department will approve or disapprove the rebasing request in a timely manner. If the rebasing is approved, the resulting increase in the prospective per diem rate will go into effect: 1)beginning with the month the cost was actually incurred if prior approval was obtained, or 2) no later than 30 days from the date of receipt of the request if retroactive approval was obtained. At no time will rebasing in excess of any applicable ceilings be allowed.

VII. RESERVE BED DAYS

Reserve bed days will be paid using the provider's Level III rate.

VIII. RECONSIDERATION PROCEDURES FOR BASE YEAR DETERMINATIONS

A. A provider who is dissatisfied with the base year rate determination or the final settlement(in the case of a change of ownership) may request a reconsideration of the determination by addressing a Request for Reconsideration to:

Director
Medical Assistance Division
P.O. Box 2348
Santa Fe, NM 87504

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B. The filing of a Request for Reconsideration will not effect the imposition of the determination.

C. A Request for Reconsideration, to be timely, must be filed with or received by the Medical Assistance Division no later than 30 days after the date of the determination notice to the provider.

D. The written Request for Reconsideration must identify each point on which it takes issue with the audit agent and must include all documentation, citation of authority, and argument on which the request is based. Any point not raised in the original filed request may not be raised later.

E. The Medical Assistance Division will submit copies of the request and supporting material to the audit agent. A copy of the transmittal letter to the audit agent will be sent to the provider. A written response from the audit agent must be filed with or received by the Medical Assistance Division no later than 30 days after the date of the transmittal letter.

F. The Medical Assistance Division will submit copies of the audit agent's response and supporting material to the provider. A copy of the transmittal letter to the provider will be sent to the audit agent. Both parties may then come up with additional submittals on the point(s) at issue. Such follow-up submittals must be filed with or received by the Medical Assistance Division no later than 15 days after the date of the transmittal letter to the provider.

G. The Request for Reconsideration and supporting materials, the response and supporting materials, and any additional submittal will be delivered by the Medical Assistance Division Director to the Secretary, or his/her designee, within 5 days after the closing date for final submittals.

H. The Secretary, or his/her designee, may secure all information and call on all expertise he/she believes necessary to decide the issues.

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I. The Secretary, or his/her designee, will make a determination on each point at issue, with written findings and will mail a copy of the determinations to each party within 30 days of the delivery of the material to him. The Secretary's determinations on appeals will be made in accordance with the applicable provisions of the plan. The Secretary's decision will be final and any changes to the original determination will be implemented pursuant to that decision.

IX. PUBLIC DISCLOSURE OF COST REPORTS

A. Provider's cost reports submitted by participating providers as a basis for reimbursement as required by law are available to the public upon receipt of a written request to the Medical Assistance Division. Information thus disclosed is limited to cost report documents required by Social Security Administration regulations and, in the case of a settled cost report, the notice of program settlement.

B. The request must identify the provider and the specific report(s) requested.

C. The cost for copying will be charged to the requestor.

X. SEVERABILITY

If any provision of this regulation is held to be invalid, the remainder of the regulations shall not be affected thereby.